ANNUAL MORBIDITY SUMMARY

UTAH DEPARTMENT OF HEALTH
SELECTED REPORTABLE DISEASES

PROVISIONAL DATA 1984

County	Estimated Population 1983	Colorado Tick Fever	Gonorrhea	Hepatitis (A, Non-A, Non-B, & Unspecified)	Hepatitis B	Influenza	Meningitis (Bacterial)	Meningitis (Non-bacterial)	Meningococcal Infections	Psittacosis	Rabies (Animal)	Rubella	Rubeola	Salmonellosis	Shigellosis	Syphilis (less than 1 year duration)	Tuberculosis (New Active & Relapse)	Tularemia
Beaver	4,950			2			1					1						
Box Elder	34,300	1	10	4	1	9	4	6						3				
Cache	64,000		23	3	1	257	6	3	1				1	9	2		1	
Carbon	24,000	2	4	6	1										1		2	
Daggett	800						1											
Davis	160,800	3	88	82	11	1729	12	4	1		1	3	9	8	2		1	
Duchesne	14,050		1	2			2							1				1
Emery	12,750		3	1		10												
Garfield	3,950													1				
Grand	7,950	1	1	5											1			
Iron	18,600		1	5	2		2							5				
Juab	5,850				1									2				
Kane	4,250																	
Millard	11,250		1	1	1	1												
Morgan	5,300			4	1													1
Piute	1,500																	
Rich	2,250	1																
Salt Lake	666,000	8	873	97	56	207	54	48	5	1	1	2	17	48	32	20	27	2
San Juan	12,900		30	1		54	2							1	12			
Sanpete	16,700		1			391												1
Sevier	16,650	1	1														1	
Summit	11,700		11		1	1	3							2				
Tooele	27,000	1	9	24	4	2	2							4	2			
Uintah	24,600		7	23		125	1							1				1
Utah	240,700	3	50	104	9	315	10	3	2		4			20	11	3	1	
Wasatch	8,850		3	2		2								3				
Washington	30,800		14	1	5	190	2								2		1	
Wayne	2,150	1																
Weber	152,900	1	177	129	12	2	9	1				1		10	9	12	6	
Utah State Total	1,587,500	23	1308	496	106	3295	111	65	9	1	6	7	27	118	74	35	40	6
1983		33	1362	221	83	1501	81	61	12	0	11	7	22	114	105	36	46	9

Other Diseases: INFANT BOTULISM - 2, CAMPYLOBACTER - 38, CYTOMEGALOVIRUS - 21, ENCEPHALITIS - 18, GIARDIASIS = 350, GUILLAIN-BARRE - 1, KAWASAKI SYNDROME - 6, LEGIONELLOSIS - 8, LEPROSY - 1, MALARIA = 5, MUMPS - 14, PLAGUE - 2, REYE SYNDROME - 4, JAKOB-CREUTZFELDT - 3, TRICHINOSIS - 1

AIDS 1984 CUMULATIVE TOTAL - 8

TOXIC-SHOCK SYNDROME 1984 CUMULATIVE TOTAL - 19

1-11-85

A&D Applications

	Degree (Master of Social Work)
✓ JIM SHELTON	MSW + ~~licensed certified~~ Counselor
✓ DAVID-BALLANTYNE	MS + licensed in Ut.
* ✓ ~~Robert~~ BLANTHORN	MSW
✓ JOHN C. MEEK -	Phd EdD
✓ Aubrey M. House	Phd
✓ KAY HARRISON	B.S. → Social work
JAMES F. COX	-
RAY L Clegg	-
Roger N. Anderson	-
✓ Richard Bachstetter	MS

WASATCH COUNTY
BOARD OF HEALTH
R. R. Green, MD

ROBERT BLANTHORN

924 East 200 South
Salt Lake City, Utah 84102
(801) ~~355-0252~~ 484-1340 or 882-3397
756-8270

OBJECTIVE: A position allowing utilization of my administrative and clinical skills in Social Work/ people assisting setting.

EDUCATION:

Master of Social Work - June 1984
University of Utah, Salt Lake City, Utah
Emphasis: Dual track clinical/administration classes and internships.

Bachelor of Science - March 1981
Animal Science
Agribusiness, Minor
Utah State University, Logan, Utah

INTERNSHIPS:

US Veterans Hospital, Salt Lake City, Utah
The Haven Helping Hand Association (Residential Alcohol) Salt Lake City, Utah
University of Utah Hospital (Drug and Alcohol) Salt Lake City, Utah

SELECTED ADMINISTRATIVE EXPERIENCE:

Experience in the design, writing and admission of proposals for agency funding.

School of Social Work Board of Review, Student Representative, 1983-84.

Taught assertion training and skill building classes to Veterans.

Program (alcohol) evaluation, development, implementation and analysis.

Designed and implemented Intake Form.

SELECTED CLINICAL EXPERIENCE:

I have specialized in Alcohol and Drug Treatment in all my internships. This includes work with individuals, groups, couples, couple groups, women, probationers, parolees, aged and referrals from employment rehabilitation programs.

Skills in the use of agency referrals to community resources, especially those helpful in the alcohol/ drug area.

OTHER EMPLOYMENT EXPERIENCE:

Snow Meadow Dairy; Assistant Manager/Herdsman; 1982

Skull Valley Cattle Co.; Cowhand; September 1981 - November 1981.

Amhurst Construction; Apprentice Carpenter/Laborer; 1981.

Desert Springs Inc.; Dude Ranch Manager; May 1980 - October 1980.

Campbell Construction; Concrete Laborer; May 1979 - October 1979.

Terracor Corp.; Concrete Flatworker; April 1978 - October 1978.

PERSONAL DATA:

Born: July 2, 1956; good health; I enjoy reading, rodeo, and other sports for hobbies; and I am willing to relocate.

REFERENCES:

Available upon request from:

Placement Center, University of Utah
2180 Annex
Salt Lake City, Utah 84112
(801) 581-6186

WASATCH CITY-COUNTY HEALTH DEPARTMENT

55 WEST CENTER
HEBER CITY, UTAH 84032
PHONE 654-2700

January 18, 1985

Food Serdice from Home

COPY

TO: Heber City Council

FROM: Wasatch City-County Health Department

RE: Health Department Requirements for Home Food Service Operation

It has been brought to the health department's attention that there is some question regarding health department requirements for food service establishment operations that are run out of an individuals' home.

In order for the health department to give a permit to operate a food establishment there are basic requirements that must be met. These requirements pertain not only to large restaurant facilities but also to small facilities where limited food preparation takes place. The basic purpose is to promote and protect the public health.

If food preparation occurs in a home with the intent of making a business out of the operation the home would have to meet requirements of the Food Service Sanitation Regulations. Part of this regulation states that "No operation of a food service establishment shall be conducted in any room used as living or sleeping quarters. Food service operations shall be seperated from any living or sleeping quarters by complete partitioning and solid,self-closing doors." "The traffic of unnecessary persons through the food preparation areas is prohibited."

It is generally recognized that the intent of the food code would dictate that when a food service facility is operated out of a home that:

1) There be a separate opening into the home that goes into the food service area.

2) If the same opening serves as an entrance into the living area of the home, a hallway would have to be provided so that usual family traffic would not go through the food service area.

3) The kitchen that is used for the family could not be used for the food service operation.

We feel that in order to avoid problems with issuing business licenses to individuals that may not be able to meet health department requirements that a Permit to Operate a Food Establishment be obtained from the health department before a business license is issued.

We do not intend to try and inspect and regulate all the food preparation for friends, family members, church groups, etc., but we do intend to try and have everyone in the business of food service to have proper permits and licenses and conduct their operations in such a manner as to protect the public health.

If you have any questions, please feel free to contact me. I would be happy to clarify or enlarge on any questions you might have.

Thank You,

Phil D. Wright

Phil D. Wright, M.S.,R.S.
Health Officer

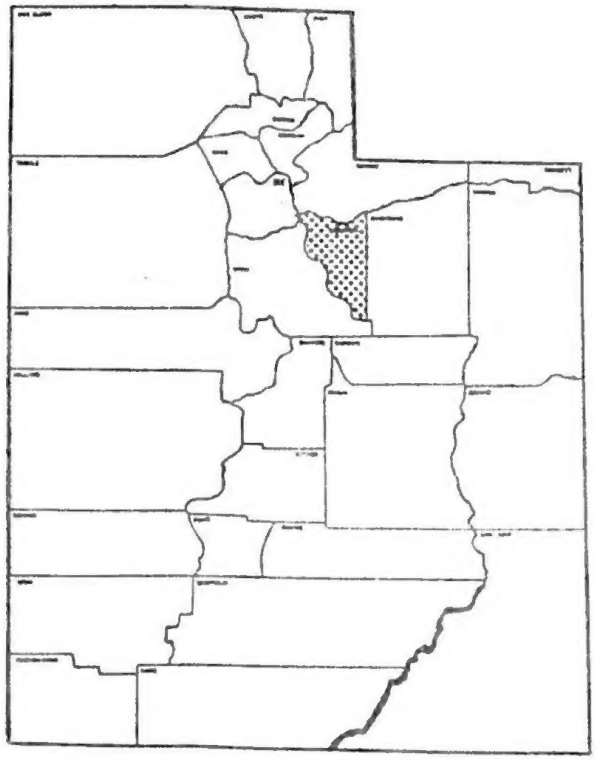
WASATCH CITY-COUNTY BOARD OF HEALTH MEMBERS

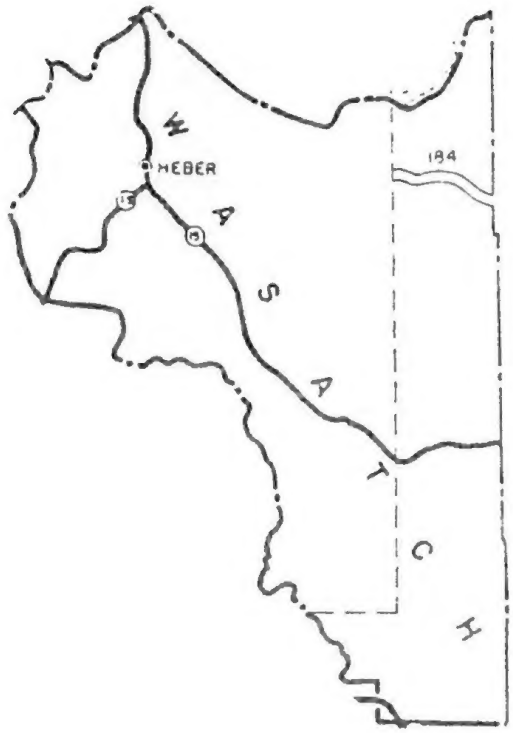
MEMBER	OCCUPATION	ADDRESS	TERM	TEL#
Calvin Giles Chairman	Dairyman	651 So. Mill Rd. Heber, Utah	9/9/87	654-1346
Connie Tatton Vice-chairman	Homemaker	50 North 100 East Midway, Utah	9/6/88	654-2416
Elizabeth Murdock	Homemaker	489 East 6th South Heber City, Utah	9/6/89	654-0701
Rulon Phillips	Custodian	Wallsburg, Utah	9/6/86	
Lynn Webster	Construction	RFD Box 346 Heber, Utah	9/6/89	654-2046
Raymond Green,M.D.	Physician	45 North Main Heber City, Utah	9/6/90	654-1822
Larry B. Duke,DDS	Commissioner	625 East 550 North Heber City,Utah	9/6/90	654-1736

WASATCH CITY-COUNTY HEALTH DEPARTMENT PERSONNEL

MEMBER	OCCUPATION	HOME ADDRESS	TEL#
Phil D. Wright, M.S.,R.S.	Health Officer	388 East 200 North Heber City, Utah	654-2317(H) 654-2700(O)
R. Raymond Green, M.D.	Medical Officer to Health Dept.	375 East 200 North Heber City, Utah	654-1645(H) 654-1822(O)
Ann Ranae Williams, R.D.,M.S.	Nutritionist/ Educator	561 South 1100 East Pleasant Grove, Ut.	785-6015(H) 654-2700
Maren Durtschi, R.N.	School Nurse	195 West Main Midway, Utah	654-1348(H) 654-2700(O)
Sue Barker,R.N.	Nurse Supervisor	1150 South 1200 East Heber City, Utah	654-1029(H) 654-2700(O)
Nelda Duke	Secretary	3065 So. Daniel Rd. Heber City, Utah	654-0139(H) 654-2700(O)
Patty Tucker	P/T Secretary	545 Homestead Drive Midway, Utah	654-3257(H) 654-2700(O)

WASATCH COUNTY





WASATCH COUNTY

CATEGORY	YEAR	TOTAL
Population	1980	8523
	1985	9250
Population Projection	1990	10100
	2000	11500
Population 65+	1980	779
Live Births	1980	268
	1981	245
	1982	254
	1983	199
	1984	241
Infant Mortality Rate	1984	--
Teenage Fertility Rate	1983	32.2
	1984	58.0
Fertility Rate	1983	89.1
	1984	104.8
Unemployment Rate	1985	14.7
County Poverty Levels		
Population below 75%	1980	340
Population Between 75-125%	1980	1184
Population between 125-149%	1980	553
Population between 150-199%	1980	1273
Population 200% or above	1980	5087
Population below poverty level	1985	13.4%
Primary Care Physicians		
Family Practice	1984	6
Pediatrics	1984	1

WASATCH COUNTY
(Continued)

CATEGORY	YEAR	TOTAL BEDS
Hospitals		
Wasatch County Hospital	1984	40
Nursing Homes		
Heber Valley Care Center	1984	49

copy # 2

WASATCH CITY-COUNTY HEALTH DEPARTMENT

55 WEST CENTER
HEBER CITY, UTAH 84032
PHONE 654-2700

January 21, 1985

MEMO

TO: Wasatch County Commission

FROM: Wasatch City/County Health Department

The task force on the funding of local health department services met on January 18, 1985 to finalize recommendations for the funding of state monies to the local health departments.

The recommendations from that group was:

1. That they should hold harmless the amount of monies now allocated to local health departments.

2. When new monies are allocated to the health departments, the monies will be distributed as follows:

   a) The cost of living increases approved by the state legislature would be passed on to the local health departments at the same percentage.

   b) All other monies over the cost of living that is approved by the legislature will be apportioned to the local health departments by the so called Curtis 60-40 Formula (copy enclosed)which basically states that the monies will be allocated 60% by population and 40% by area and number of counties in the health jurisdiction.

If the current monies used for general health services were given to us using this formula, we would receive $20,468. We currently receive $8,909.

This committee also gave their unified support of having the State of Utah pick up the .25 mil for the funding of the.Medical Indigent Program.

If you have any questions, please let me know.

Thank You,

Phil

Phil D. Wright, M.S.,R.S.
Health Officer

district 4 #2
County = 1
Wasa - city/co =

	60% OF STATE FUNDS			40% OF STATE FUNDS							
	ALLOCATION BASED ON POPULATION			1/3 ALLOCATION BASED ON SQUARE MILES			2/3 ALLOCATION BASED ON POINT FORMULA				
LOCAL HEALTH DEPT.	POPULATION	%	ALLOCATION	SQUARE MI	%	ALLOCATION	POINTS	%	ALLOCATION	TOTAL	%
Bear River District							4	5.2%	$16,181	$16,181	1.4%
Box Elder	34,889	2.2%	$15,470	5,603	7.0%	$10,973	1	1.3%	4,045	30,489	2.6%
Cache	63,901	4.0%	28,334	1,174	1.5%	2,299	1	1.3%	4,045	34,679	3.0%
Rich	2,142	0.1%	950	1,023	1.3%	2,004	1	1.3%	4,045	6,999	0.6%
District Total	100,932	6.4%	44,754	7,800	9.8%	15,276	7	9.1%	28,316	88,347	7.6%
								0.0%	0		
Central Utah Dist.							4	5.2%	16,181	16,181	1.4%
Juab	5,820	0.4%	2,581	3,412	4.3%	6,682	1	1.3%	4,045	13,308	1.1%
Millard	11,626	0.7%	5,155	6,793	8.5%	13,304	1	1.3%	4,045	22,504	1.9%
Piute	1,559	0.1%	691	754	0.9%	1,477	1	1.3%	4,045	6,213	0.5%
Sanpete	16,646	1.1%	7,381	1,597	2.0%	3,128	1	1.3%	4,045	14,554	1.2%
Sevier	15,456	1.0%	6,853	1,929	2.4%	3,778	1	1.3%	4,045	14,677	1.3%
Wayne	2,143	0.1%	950	2,486	3.1%	4,869	1	1.3%	4,045	9,864	0.8%
District Total	53,250	3.4%	23,612	16,971	21.3%	33,238	10	13.0%	40,452	97,301	8.3%
								0.0%	0		
Southeastern Dist.							4	5.2%	16,181	16,181	1.4%
Carbon	23,568	1.5%	10,450	1,476	1.9%	2,891	1	1.3%	4,045	17,386	1.5%
Emery	12,321	0.8%	5,463	4,439	5.6%	8,694	1	1.3%	4,045	18,202	1.6%
Grand	7,759	0.5%	3,440	3,682	4.6%	7,211	1	1.3%	4,045	14,697	1.3%
San Juan	13,022	0.8%	5,774	7,707	9.7%	15,094	1	1.3%	4,045	24,913	2.1%
District Total	56,670	3.6%	25,128	17,304	21.8%	33,890	8	10.4%	32,362	91,380	7.8%
								0.0%	0		
Southwestern Dist.							4	5.2%	16,181	16,181	1.4%
Beaver	5,121	0.3%	2,271	2,584	3.2%	5,061	1	1.3%	4,045	11,377	1.0%
Garfield	3,916	0.2%	1,736	2,584	3.2%	5,061	1	1.3%	4,045	10,842	0.9%
Iron	18,553	1.2%	8,227	3,300	4.1%	6,463	1	1.3%	4,045	18,735	1.6%
Kane	4,113	0.3%	1,824	3,904	4.9%	7,646	1	1.3%	4,045	13,515	1.2%
Washington	30,909	2.0%	13,705	2,427	3.1%	4,753	1	1.3%	4,045	22,504	1.9%
District Total	62,612	4.0%	27,763	14,799	18.6%	28,984	9	11.7%	36,407	93,153	8.0%
								0.0%	0		
Uintah Basin Dist.							4	5.2%	16,181	16,181	1.4%
Daggett	732	.0%	325	682	0.9%	1,336	1	1.3%	4,045	5,705	0.5%
Duchesne	13,925	0.9%	6,175	3,255	4.1%	6,375	1	1.3%	4,045	16,595	1.4%
Uintah	24,383	1.5%	10,812	4,487	5.6%	8,788	1	1.3%	4,045	23,645	2.0%
District Total	39,040	2.5%	17,311	8,424	10.6%	16,498	7	9.1%	28,316	62,126	5.3%
								0.0%	0		
Weber-Morgan Dist.							4	5.2%	16,181	16,181	1.4%
Morgan	5,354	0.3%	2,374	603	0.8%	1,181	1	1.3%	4,045	7,600	0.7%
Weber	152,084	9.6%	67,436	581	0.7%	1,138	1	1.3%	4,045	72,619	6.2%
District Total	157,438	10.0%	69,810	1,184	1.5%	2,319	6	7.8%	24,271	96,400	8.3%
Davis County	160,189	10.1%	71,030	297	0.4%	582	5	6.5%	20,226	91,837	7.9%
Salt Lake City/Co.	663,217	42.0%	294,078	764	1.0%	1,496	5	6.5%	20,226	315,800	27.0%
Summit County	11,799	0.7%	5,232	1,849	2.3%	3,621	5	6.5%	20,226	29,079	2.5%
Tooele County	26,810	1.7%	11,888	6,923	8.7%	13,559	5	6.5%	20,226	45,673	3.9%
Utah City/County	239,768	15.2%	106,316	2,014	2.5%	3,944	5	6.5%	20,226	130,486	11.2%
Wasatch County	8,816	0.6%	3,909	1,191	1.5%	2,333	5	6.5%	20,226	26,468	2.3%
STATE TOTAL	1,580,541	100%	$700,830	79,520	100%	$155,740	77	100%	$311,480	$1,168,050	100%

DISTRIBUTION OF STATE GENERAL HEALTH FUNDS
TO LOCAL HEALTH DEPARTMENTS
YEAR ENDED JUNE 30, 1984

Local Health Department	Population	Actual Expenditures	State General Health Funds	State General funds as a Percentage of Total Expenditures	Percentage of all State General Health Funds to LHD	State General Health Funds Per Capita
Bear River District	101,550	$ 998,305	$ 130,753	13.1%	11.2%	$1.29
Central Utah District	53,100	518,901	167,513	32.3	14.3	3.15
Southeastern District	57,600	1,346,292	163,770	12.2	14.0	2.84
Southwestern District	62,550	1,066,024	167,189	15.7	14.3	2.67
Uintah Basin District	39,450	384,549	125,794	32.7	10.8	3.19
Weber-Morgan District	158,200	1,406,468	111,931	8.0	9.6	.71
Davis County	160,800	1,301,264	43,885	3.4	3.8	.27
Salt Lake City-County	666,000	6,252,660	167,485	2.7	14.3	.25
Summit County	11,700	326,888	7,088	2.2	.6	.61
Tooele County	27,000	262,194	12,425	4.7	1.1	.46
Utah City-County	240,700	1,445,029	61,308	4.2	5.2	.25
Wasatch County	8,850	129,799	8,909	6.9	.8	1.01
	1,587,500	$15,438,373	$1,168,050	7.6%	100 %	$ .74

WASATCH CITY-COUNTY HEALTH DEPARTMENT

55 WEST CENTER
HEBER CITY, UTAH 84032
PHONE 654-2700

January 21, 1985

MEMO

TO: Wasatch County Commission

FROM: Wasatch City/County Health Department

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If you have any questions, please let me know.

Thank You,

Phil D. Wright, M.S.,R.S.
Health Officer

District 4
Coun

Wasatch city /co =

	60% OF STATE FUNDS			40% OF STATE FUNDS							
	ALLOCATION BASED ON POPULATION			1/3 ALLOCATION BASED ON SQUARE MILES			2/3 ALLOCATION BASED ON POINT FORMULA				
LOCAL HEALTH DEPT.	POPULATION	%	ALLOCATION	SQUARE MI	%	ALLOCATION	POINTS	%	ALLOCATION	TOTAL	%
Bear River District							4	5.2%	$16,181	$16,181	1.4%
Box Elder	34,889	2.2%	$15,470	5,603	7.0%	$10,973	1	1.3%	4,045	30,489	2.6%
Cache	63,901	4.0%	28,334	1,174	1.5%	2,299	1	1.3%	4,045	34,679	3.0%
Rich	2,142	0.1%	950	1,023	1.3%	2,004	1	1.3%	4,045	6,999	0.6%
District Total	100,932	6.4%	44,754	7,800	9.8%	15,276	7	9.1%	28,316	88,347	7.6%
								0.0%	0		
Central Utah Dist.							4	5.2%	16,181	16,181	1.4%
Juab	5,820	0.4%	2,581	3,412	4.3%	6,682	1	1.3%	4,045	13,308	1.1%
Millard	11,626	0.7%	5,155	6,793	8.5%	13,304	1	1.3%	4,045	22,504	1.9%
Piute	1,559	0.1%	691	754	0.9%	1,477	1	1.3%	4,045	6,213	0.5%
Sanpete	16,646	1.1%	7,381	1,597	2.0%	3,128	1	1.3%	4,045	14,554	1.2%
Sevier	15,456	1.0%	6,853	1,929	2.4%	3,778	1	1.3%	4,045	14,677	1.3%
Wayne	2,143	0.1%	950	2,486	3.1%	4,869	1	1.3%	4,045	9,864	0.8%
District Total	53,250	3.4%	23,612	16,971	21.3%	33,238	10	13.0%	40,452	97,301	8.3%
								0.0%	0		
Southeastern Dist.							4	5.2%	16,181	16,181	1.4%
Carbon	23,568	1.5%	10,450	1,476	1.9%	2,891	1	1.3%	4,045	17,386	1.5%
Emery	12,321	0.8%	5,463	4,439	5.6%	8,694	1	1.3%	4,045	18,202	1.6%
Grand	7,759	0.5%	3,440	3,682	4.6%	7,211	1	1.3%	4,045	14,697	1.3%
San Juan	13,022	0.8%	5,774	7,707	9.7%	15,094	1	1.3%	4,045	24,913	2.1%
District Total	56,670	3.6%	25,128	17,304	21.8%	33,890	8	10.4%	32,362	91,380	7.8%
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Beaver	5,121	0.3%	2,271	2,584	3.2%	5,061	1	1.3%	4,045	11,377	1.0%
Garfield	3,916	0.2%	1,736	2,584	3.2%	5,061	1	1.3%	4,045	10,842	0.9%
Iron	18,553	1.2%	8,227	3,300	4.1%	6,463	1	1.3%	4,045	18,735	1.6%
Kane	4,113	0.3%	1,824	3,904	4.9%	7,646	1	1.3%	4,045	13,515	1.2%
Washington	30,909	2.0%	13,705	2,427	3.1%	4,753	1	1.3%	4,045	22,504	1.9%
District Total	62,612	4.0%	27,763	14,799	18.6%	28,984	9	11.7%	36,407	93,153	8.0%
								0.0%	0		
Uintah Basin Dist.							4	5.2%	16,181	16,181	1.4%
Daggett	732	.0%	325	682	0.9%	1,336	1	1.3%	4,045	5,705	0.5%
Duchesne	13,925	0.9%	6,175	3,255	4.1%	6,375	1	1.3%	4,045	16,595	1.4%
Uintah	24,383	1.5%	10,812	4,487	5.6%	8,788	1	1.3%	4,045	23,645	2.0%
District Total	39,040	2.5%	17,311	8,424	10.6%	16,498	7	9.1%	28,316	62,126	5.3%
								0.0%	0		
Weber-Morgan Dist.							4	5.2%	16,181	16,181	1.4%
Morgan	5,354	0.3%	2,374	603	0.8%	1,181	1	1.3%	4,045	7,600	0.7%
Weber	152,084	9.6%	67,436	581	0.7%	1,138	1	1.3%	4,045	72,619	6.2%
District Total	157,438	10.0%	69,810	1,184	1.5%	2,319	6	7.8%	24,271	96,400	8.3%
Davis County	160,189	10.1%	71,030	297	0.4%	582	5	6.5%	20,226	91,837	7.9%
Salt Lake City/Co.	663,217	42.0%	294,078	764	1.0%	1,496	5	6.5%	20,226	315,800	27.0%
Summit County	11,799	0.7%	5,232	1,849	2.3%	3,621	5	6.5%	20,226	29,079	2.5%
Tooele County	26,810	1.7%	11,888	6,923	8.7%	13,559	5	6.5%	20,226	45,673	3.9%
Utah City/County	239,768	15.2%	106,316	2,014	2.5%	3,944	5	6.5%	20,226	130,486	11.2%
Wasatch County	8,816	0.6%	3,909	1,191	1.5%	2,333	5	6.5%	20,226	26,468	2.3%
STATE TOTAL	1,580,541	100%	$700,830	79,520	100%	$155,740	77	100%	$311,480	$1,168,050	100%

WASATCH CITY/COUNTY BOARD OF HEALTH AGENDA

February 11, 1985 — Health Office

1) Welcome Prayer Nelda
2) Approval of Minutes
3) Mountainlands contract / Senior Citizens
4) Food Permits for Home Occupations ← Verna Lewis Sweat – Phil Dorcas Anderson Mullineer (Giovanni) Recs.
5) Board Member from Charleston _ alan Brown
6) WIC – # 1980 ← 174 272 Nutrion Classes 25
7) Well Child # < 1 yr ago started – 87 to 5th year
8) Immunizations 110 Feb. {64% are current 2 consent –
9) Bat Problems
10) Longbranch Business License ← No – sewer water Not approved. 40 Oam Acres
11) Environmental Health Priority List
12. Shot Liability
13. center creek farms 10 or 12 lots (McQuarry)
14. Suzanne Dardoy {Collegiate Escapelopian

To be published 1/31/85

#1

NOTICE OF ANNUAL MEETING SCHEDULE
OF
WASATCH CITY-COUNTY BOARD OF HEALTH

Public notice is hereby given that the 1985 Monthly Meeting Schedule of the Wasatch City-County Board of Health is as follows:

January 21

February 11

March 18

April 15

May 20

June 17

July 15

August 19

September 16

October (To be scheduled)

November 18

December 16

Meetings of the health board will be held at the Health Department offices at 55 West Center, Heber City, Utah, commencing at 12:00 P.M.

Jan 31 1985

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le June 16, 1974-June 26, 1977
hard J. Klein, Counselors

UTAH DEPARTMENT OF HEALTH
DIVISION OF COMMUNITY HEALTH SERVICES
BUREAU OF EPIDEMIOLOGY

Suzanne Dandoy, M.D., M.P.H.
Executive Director

COMMUNICABLE DISEASE NEWSLETTER

Adele P. Nelson, R.N., M.P.H., Director
Division of Community Health Services

EDITOR: Craig R. Nichols, M.P.A., State Epidemiologist
Director, Bureau of Epidemiology
(801) 533-6191

MONTH March YEAR 1985

CONTENTS

UTAH IMMUNIZATION SURVEY OF TWO-YEAR-OLDS

In late 1984, a survey to determine the immunization levels of two-year-old children in Utah was conducted by the Immunization Program and local health departments.

Six hundred children were randomly selected from the 1,676 births that occurred in Utah between July 1 and July 15, 1982. Nonresident and illegitimate births, as well as those children that died in their first year of life, were not eligible for selection. The parents of these 600 children received an one-page questionnaire by mail; follow-up procedures including repeat questionnaires and personal contact to maximize response were used.

Information was obtained for 444 (74%) of the 600 selected births. Of the responses received, 221 (49.8%) were from the first letter; 81 (18.2%) from the second; and 142 (32%) as a result of Immunization Program or local health department follow-up efforts.

The results of the survey reveal a decline in immunization levels of two-year-old children since 1980 when the last two-year-old survey was conducted in Utah. Only 59.2% of the two-year-olds were determined to be fully immunized (3+ Diphtheria-Tetanus-Pertussis, 3+ Polio, 1 Measles-Mumps-Rubella), compared to 77.7% in 1980

When survey results were analyzed by individual antigen, immunization levels were found to range from 64.4% of children immunized with polio vaccine to 84.7% completely immunized with DTP vaccine. Although a large percent of children are not adequately immunized, the survey indicates that most children have started to receive the recommended series of immunizations. Parents and health care providers need to review immunization records of young children and make sure that missed doses are administered as recommended.

Extensive efforts to implement the Utah School Immunization Law over the past three years undoubtedly have negatively impacted the level of protection among preschoolers. Now that the School Immunization Law has been phased in successfully, attention and efforts must be directed to ensuring the protection of our preschool population. A variety of activities will accomplish that goal, including the improvement of (1) maternal immunization education in hospitals, (2) follow-up of children identified as "high risk", and (3) active recall of children who don't return for immunizations when due.

MENINGOCOCCAL DISEASE IN NEPAL[1]

"Between January 1984 and January 1985, 2 culture-confirmed and 4 clinically suspected cases of meningococcal meningitis and meningococcemia, 2 of which resulted in death, have been documented in tourists from western countries traveling in Nepal. Of the 6 cases, 3 occurred between January and April 1984, and 3 occurred between November 1984 and January 1985. The countries of origin of the patients were the United States (3), Australia (2), and Switzerland (1). All of the patients became ill during or shortly after trekking outside Kathmandu. Based on estimates of the number of western tourists visiting Nepal and the number of trekking permits issued during this time period, the attack rates for western tourists and trekkers were 6 and 19 per 100,000 respectively. For comparison, the expected attack rate among adults in the U.S. would be .009 per 100,000, after adjusting for the fact that the average length of stay for tourists in Nepal is 11 days.

"Although vaccination against meningococcal disease is not required for travel to any country, it is recommended that tourists planning to trek in Nepal receive meningococcal vaccine. While the cases of meningococcal disease among tourists have all been in trekkers, it is prudent for others traveling to Nepal to receive the vaccine as well.

"The serogroup A meningococcal vaccine has a clinical efficacy of 85-95% for at least one year, with protection being achieved 1-2 weeks following vaccination. Adverse reactions are limited to local erythema or soreness. There are 2 formulations of meningococcal vaccine currently available in the United States: the bivalent A-C vaccine and the quadrivalent A,C,Y,W-135 vaccine. Either formulation will give protection against serogroup A meningococcal disease; the bivalent vaccine is less expensive. The sole distributor of these vaccines in the United States is Squibb. The vaccine can be obtained through a pharmacy by contacting a Squibb regional distribution center or by calling Squibb at 1-800-VACCINE.

"Because immunity is not achieved until 1-2 weeks post-vaccination, we recommend that tourists be vaccinated prior to departure. However, vaccine is available in Nepal at the Epidemiology Division, Department of Health Services, Teku, Kathmandu."

Reference

1. Adapted from Department of Health and Human Services, Public Health Service, Centers for Disease Control. Advisory Memorandum No. 77, March 7, 1985.

INFLUENZA B

An one-month-old male from Salt Lake City developed an acute respiratory illness which led to hospitalization during March. A throat swab yielded influenza B virus, the only type B isolate from Utah during the 1984-1985 influenza season. The baby died of pneumonia 14 days after onset of symptoms.

Influenza activity in Utah began to decline by late January, with only sporadic cases being reported through March. All influenza type A has been identified as H3N2.

Although influenza is usually a self-limited illness, mortality due to pulmonary complications does occur among the elderly, chronically ill and very young.

YELLOW FEVER VACCINATION CENTERS

Yellow fever vaccine is recommended for travelers to areas where the disease is transmitted or to countries which require an "International Certificate of Vaccination against Yellow Fever" as a condition for entry.

Urban and jungle yellow fever usually occur only in parts of Africa and South America. Urban yellow fever is an epidemic viral disease of humans transmitted by the Aedes aegypti mosquito. Jungle yellow fever is an enzootic viral disease transmitted among nonhuman primate hosts by a variety of mosquito vectors.

Information regarding immunization requirements for international travel is available from all local health departments, Utah Department of Health and private clinics. Yellow fever vaccine is only available from the following designated Yellow Fever Vaccination Centers:

Salt Lake City

University of Utah Medical Center Traveler's Clinic	[581-2275]
University of Utah Student Health Center	[581-6431]
Salt Lake City-County Health Department	[530-7500]

Provo

Brigham Young University Student Health Service	[378-2771]
Missionary Training Center Health Clinic	[378-4473]
City-County Health Department of Utah County	[375-8100]

CYTOMEGALOVIRUS IN DAY-CARE CENTERS[1]

"Public awareness that maternal primary cytomegalovirus (CMV) infection during pregnancy can result in damaging fetal infections has increased in recent years. Although little is known about how CMV is transmitted in the community, it does not appear to be highly contagious. Acquisition appears to require close or intimate contact with persons who are excreting CMV in their urine, saliva, or other secretions. CMV can also be transmitted via blood transfusions, breast milk, sexual intercourse, and transplanted organs.

"Studies have shown that infants and children acquire CMV infection from other children or from their mothers either in utero, at birth, or during the perinatal period. Intrauterine CMV infection is the most common of all recognized intrauterine infections, occurring in an estimated 0.4%-2.3% of all live births, and it can have a variable outcome. It may result from either

primary maternal infection acquired during pregnancy or from a recurrent infection (reactivation) or reinfection in a seropositive woman. Current evidence indicates that most but not all symptomatic congenital CMV infections result from primary infection of the mother. In the United States, 35%-90% of women (depending on race and socioeconomic status) entering their childbearing years are seropositive, and thus, they are not susceptible to primary CMV infection.

"CMV infection is endemic in the community, and infection in childhood is common and usually asymptomatic. Previously published results from a longitudinal study of children in a day-care center indicate that the majority of children acquired CMV after joining the center and that the estimated cumulative infection rate may reach as high as 80% for children during their second year of life. Excretion of CMV has persisted for months to years in most of the children studied at that center, as it does in congenital CMV-infected children. Another study comparing point prevalence rates of CMV excretion in urine and saliva of children attending infant development centers for the developmentally delayed and those in day-care centers demonstrated that urinary excretion occurred in 22% of children in both types of centers. Since CMV infection appears to be endemic in the day-care setting, there is very little justification for excluding a child from these settings because the child is known to be excreting CMV.

"Unfortunately, concern over the risk of acquiring CMV infection from children known to have congenital infection has led to placement of unwarranted restrictions in some communities on the participation of these children in public programs, such as day care, schools, and even intervention programs for the developmentally disabled. The risk of exposure from a child with congenital CMV infection is minimal, compared to the unavoidable exposures to the many healthy children in the general population who are unrecognized excretors of CMV. The risk of spread of CMV infection to child-care personnel, particularly women of childbearing age, is not fully known. Until more data are available on occupational infections and the potential risk of exposure to pregnant workers, female employees in their reproductive years should be informed that a significant percentage of infected children may be present in any child-care setting, and that care for any infants and children should include hygienic measures, such as washing hands after each contact with urine and respiratory-tract or other potentially infectious scretions and careful handling and disposal of diapers and other articles known to be contaminated with urine or other secretions.

"Routine serologic testing of pregnant women who take care of children in institutions is not currently indicated because: the extent of risk is not currently established; testing facilities are not readily available; and the significance of antibody titer in a single test is difficult to interpret. Also, it is not known whether the risk of primary CMV infection would be appreciably reduced by identifying seronegative women and transferring them to areas where there is less contact with infants and children. Until further data are available, the most practical means by which pregnant women or women planning pregnancy can prevent acquiring CMV is rigorous, good personal hygiene throughout pregnancy, particularly in any setting where frequent, close contact with infants and children occur." [References available on request.]

Reference

1. Adapted from Morbidity and Mortality Weekly Report, Vol.34/No.4, February 1, 1985.

Free Physical Exams

Offered for Senior Citizens

21 Mar 1985

The Wasatch City-County Health Department in co-operation with the Wasatch County Senior Citizens is sponsoring free physical exams for the senior citizens (age 60 and above) of Wasatch County. The exam is for health screening only.

The health department has arranged to have the exams performed at the doctors office. The following doctors will assist the health department in providing the exams: Dr. Janet Kelly, Dr. Bill Ferguson, Dr. R. Raymond Green, Dr. Stanton McDonald, Dr. Neal Burton and Dr. George Pitts.

All those interested in this program can report to the health department where approval can be obtained to set up appointments with the participating doctors. Services will be available on a first come first served basis until June or until funding is exhausted.

If you have any questions contact the health department at 55 West Center or call 654-2700.

Phil Wright Elected to State Office

28 Mar 1985

Mr. Phil Wright has just recently returned from a meeting of the Health Directors of Utah in St. George, Utah. Mr. Wright serves as president of the Utah Health Officers Association which is composed of Health Directors from every Health District in the State of Utah.

Mr. Wright is the Director of the Wasatch County Health Department located at 55 West Center, Heber. He is married to Kathryn Muhlestein and has seven children. He is a member of the Heber Utah East Stake Presidency and is an active member of the community. He is a graduate of Brigham Young University where he obtained a Master of Science Degree in parasitilogy and he is a Registered Sanitarian. Prior to working for the County Health Department, Mr. Wright was an inspector for the State Department of Agriculture.

Mr. Wright has been influential in bringing several important health services to Wasatch County.

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Phil Wright

UTAH DEPARTMENT OF HEALTH
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COMMUNICABLE DISEASE NEWSLETTER

Adele P. Nelson, R.N., M.P.H., Director
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EDITOR: Craig R. Nichols, M.P.A., State Epidemiologist
Director, Bureau of Epidemiology
(801) 533-6191

MONTH April YEAR 1985

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MALARIA PREVENTION GUIDELINES

The December 1984 Communicable Disease Newsletter reported that malaria prevention guidelines had been modified because of adverse reactions to pyrimethamine-sulfadoxine (Fansidar). Interim guidelines issued in December have now been replaced by "Revised Recommendations for Preventing Malaria in Travelers to Areas with Chloroquine-Resistant Plasmodium falciparum" which were published in the Morbidity and Mortality Weekly Report, April 12, 1985 (Vol. 34/No. 14).

The new recommendations differ significantly from previous guidelines and were formulated to address specific recommendations for each area where transmission of chloroquine-resistant strains of Plasmodium falciparum is known to occur.

The length of the revised recommendations precludes complete publication in this newsletter. However, single, complimentary copies are available from the Bureau of Epidemiology. Travelers and physicians can also obtain advice on malaria chemoprophylaxis from local health departments, the Bureau of Epidemiology and private clinics offering vaccines for foreign travel.

The following statements abstracted from the guidelines are provided only to demonstrate the extent that malaria prevention guidelines have been modified. The complete recommendations should be reviewed before advising travelers.

TRAVELERS TO AREAS IN AFRICA WITH CRPF

Short-Term Travel. For short-term travelers (3 weeks or less) to areas of Africa with chloroquine-resistant Plasmodium falciparum (CRPF), the weekly use of chloroquine alone is recommended. In addition, these travelers (except those with histories of sulfonamide or pyrimethamine intolerance) should be given a single treatment dose of Fansidar to be kept in their possession during travel and should be advised to take the Fansidar promptly in the event of a febrile illness during or after their travel when professional medical care is not readily available. It must be emphasized to travelers that such presumptive self-treatment of a possible malarial infection is only a temporary measure and that professional medical follow-up care as soon as possible is imperative. They should also be advised to continue weekly chloroquine prophylaxis after presumptive treatment with Fansidar.

Longer-Term Travel. Because persons with prolonged exposure in areas of CRPF transmission are at higher risk of acquiring malaria, the use of combined weekly prophylaxis with chloroquine and Fansidar can be considered. The potential benefit of the routine prophylactic use of Fansidar for these travelers must be weighed against the risk of a possible serious or fatal adverse reaction.

TRAVELERS TO AREAS IN CHINA AND SOUTHEAST ASIA WITH CRPF

Malaria chemoprophylaxis is not recommended for travelers who will visit only urban centers of Asia or who will have only daytime exposure in rural areas. This includes most travelers to China, Indonesia, Malaysia, the Philippines, and Thailand.

Travelers who veer from the usual tourist routes of these areas and who will have outdoor exposure in rural, malarious areas during evening and nighttime hours should be given consideration similar to travelers to CRPF areas of Africa as previously described. Special consideration should be given to travelers who will have substantial exposure in rural areas of Thailand, where widespread resistance to both chloroquine and Fansidar has been reported. Regimens for these travelers should be made in consultation with local or state health departments or CDC.

TRAVELERS TO AREAS OF SOUTH AMERICA WITH CRPF

Travelers to areas of South America with CRPF should be advised in the use of chemoprophylaxis regimens as previously described for China and Southeast Asia.

TRAVELERS TO THE INDIAN SUBCONTINENT

Chloroquine prophylaxis alone is recommended for travelers to the Indian subcontinent.

TRAVELERS TO OCEANIA

Malaria transmission in many areas of Papua New Guinea, Irian Jaya, the Solomon Islands, and Vanuatu is intense and in some areas may approximate that found in malarious areas of Africa. Travelers to these areas should, therefore, be advised in the use of the chemoprophylaxis regimens previously described for travelers to CRPF areas of Africa.

NEW EDITION - CONTROL OF COMMUNICABLE DISEASES IN MAN

The American Public Health Association has released the 14th Edition (1985) of Control of Communicable Diseases in Man, a paperback reference containing information on disease identification, patient management and methods to control spread of communicable diseases.

Copies may be ordered directly from the American Public Health Association (APHA), 1015 Fifteenth Street NW, Washington, D.C. 20005. The single copy price of $9.00 includes postage and handling, and prepayment must accompany the order. Discounts are available to APHA members. The book will also be available from bookstores, especially those who stock medical reference texts.

Polysaccharide Vaccine for Prevention of *Haemophilus influenzae* Type b Disease

INTRODUCTION

A polysaccharide vaccine* against invasive (bacteremic) disease caused by *Haemophilus influenzae* type b recently has been licensed in the United States. The purposes of this statement are to summarize available information about this vaccine and to offer guidelines for its use in the prevention of invasive *H. influenzae* type b disease.

HAEMOPHILUS INFLUENZAE DISEASE

H. influenzae is a leading cause of serious systemic bacterial disease in the United States. It is the most common cause of bacterial meningitis, accounting for an estimated 12,000 cases annually, primarily among children under 5 years of age. The mortality rate is 5%, and neurologic sequelae are observed in as many as 25%-35% of survivors. Virtually all cases of *H. influenzae* meningitis among children are caused by strains of type b (Hib), although this capsular type represents only one of the six types known for this species. In addition to bacterial meningitis, Hib is responsible for other invasive diseases, including epiglottitis, sepsis, cellulitis, septic arthritis, osteomyelitis, pericarditis, and pneumonia. Nontypeable (noncapsulated) strains of *H. influenzae* commonly colonize the human respiratory tract and are a major cause of otitis media and respiratory mucosal infection but rarely result in bacteremic disease. Hib strains account for only 5%-10% of *H. influenzae* causing otitis media.

Several population-based studies of invasive Hib disease conducted within the last 10 years have provided estimates of the incidence of disease among children under 5 years of age, the major age group at risk. These studies have demonstrated attack rates of meningitis ranging from 51 cases per 100,000 children to 77/100,000 per year and attack rates of other invasive Hib disease varying from 24/100,000 to 75/100,000 per year (*1*). Thus, in the United States, approximately one of every 1,000 children under 5 years of age develops systemic Hib disease each year, and a child's cumulative risk of developing systemic Hib disease at some time during the first 5 years of life is about one in 200. Attack rates peak between 6 months and 1 year of age and decline thereafter. Approximately 35%-40% of Hib disease occurs among children 18 months of age or older, and 25% occurs above 24 months of age.

Incidence rates of Hib disease are increased in certain high-risk groups, such as Native Americans (both American Indians and Eskimos), blacks, individuals of lower socioeconomic status, and patients with asplenia, sickle cell disease, Hodgkin's disease, and antibody deficiency syndromes. Recent studies also have suggested that the risk of acquiring primary Hib disease for children under 5 years of age appears to be greater for those who attend day-care facilities than for those who do not (*2,3*).

The potential for person-to-person transmission of systemic Hib disease among susceptible individuals has been recognized in the past decade. Studies of secondary spread of Hib disease in household contacts of index patients have shown a substantially increased risk of disease among exposed household contacts under 4 years of age (*4*). In addition, numerous clusters of cases in day-care facilities have been reported, and recent studies suggest that secondary attack rates in day-care classroom contacts of a primary case also may be increased (*5,6*).

HAEMOPHILUS b POLYSACCHARIDE VACCINE

The Hib vaccine is composed of the purified, capsular polysaccharide of *H. influenzae* type b ([→3] ribose-β1 →1 ribitol-1 phosphate-5→). Antibodies to this antigen correlate with protection against invasive disease. The Hib vaccine induces an antibody response that is directly related to the age of the recipient; infants respond infrequently and with less antibody than do older children or adults (*7*). Improved responses are observed by 18 months of age, although children 18-23 months of age do not respond as well as those 2 years of age or older. The frequency and magnitude of antibody responses reach adult levels at about 6 years of age (*8,9*). Levels of antibodies to the capsular polysaccharide also decline more rapidly in immunized infants and young children than in adults.

In a manner similar to other polysaccharide antigens, revaccination with Hib vaccine results in a level of antibody comparable to that for a child of the same age receiving a first immunization (*10*). Such polysaccharide antigens have been termed "T-cell independent" because of their failure to induce the T-cell memory response characteristic of protein antigens.

Limited data are available on the response to Hib vaccine in high-risk groups with underlying disease. By analogy to pneumococcal vaccine, patients with sickle cell disease or asplenia are likely to exhibit an immune response to the Hib vaccine. Patients with malignancies associated with immunosuppression appear to respond less well. Additional data on the immune response to Hib vaccine in these groups are needed.

A precise protective level of antibody has not been established. However, based on evidence from passive protection in the infant rat model and from experience with agammaglobulinemic children, an antibody concentration of 0.15 μg/ml correlates with protection (*7,8,11*). In the Finnish field trial, levels of capsular antibody greater than 1 μg/ml in 3-week postimmunization sera correlated with clinical protection for a minimum of 1½ years (*9,12,13*). Approximately 75% of children 18-23 months of age tested achieved a level greater than 1 μg/ml, as did 90% of 24-35 month old children (*9*). Measurement of Hib antibody levels is not routinely available, however, and determination of antibody levels following vaccination is not indicated in the usual clinical setting.

EFFECTIVENESS OF VACCINE

In 1974, a randomized, controlled trial of clinical efficacy was conducted in Finland among children 3-71 months of age (*9*). Approximately 98,000 children, half of whom received the Hib vaccine, were enrolled in the field trial and followed for a 4-year period for occurrence of Hib disease. Among children 18-71 months of age, 90% protective efficacy (95% confidence limits, 55%-98%) in prevention of all forms of invasive Hib disease was demonstrated for the 4-year follow-up period. Although no disease occurred among over 4,000 children 18-23 months of age immunized with Hib vaccine and followed for 4 years, only two cases occurred in the control vaccine recipients in this age group. As a result, vaccine efficacy in the subgroup of children immunized at 18-23 months of age could not be evaluated statistically. The vaccine was not efficacious in children under 18 months of age.

REVACCINATION

Limited data regarding the potential need for revaccination are available at present. Current data show that children who have received the Hib vaccine 2-42 months previously have an immune response to the vaccine similar to that in previously unvaccinated children of the same age. No immunologic tolerance or impairment of immune response to a subsequent dose of vaccine occurs (*10*). As with other polysaccharide vaccines, the shorter persistence of serum antibodies in young children given Hib vaccine, compared with adults, suggests that a second dose of vaccine may be needed to maintain immunity throughout the period of risk, particularly for children in the youngest age group considered for vaccination (those 18-23 months of age). A second injection following the initial dose is likely to increase the protective benefit of vaccination for this high-risk group, because antibody titers 18 months after vaccination, although detectable in most vaccine recipients, are no longer significantly different from those in unvaccinated children of the same age.

*Official name: Haemophilus b Polysaccharide Vaccine.

RECOMMENDATIONS FOR VACCINE USE

Recently published data regarding vaccine efficacy and the risk of Hib disease among young children strongly support the use of Hib vaccine in the United States in high-risk persons for whom efficacy has been established. Specific recommendations are as follows:

1. **Immunization of all children at 24 months of age is recommended.** The precise duration of immunity conferred by a single dose of Hib vaccine at 24 months of age is not known, although, based on available data, protection is expected to last 1½-3½ years. Until further data are available to determine whether an additional dose of vaccine may be necessary to ensure long-lasting immunity, routine revaccination is not recommended.
2. **Immunization of children at 18 months of age, particularly those in known high-risk groups, may be considered.** Although the precise efficacy of the vaccine among children 18-23 months of age is not known, this age group accounts for approximately 12% of all invasive Hib disease among children under 5 years of age, and Hib vaccine has been shown by serologic methods to be immunogenic in most children of this age group. However, physicians and parents should be informed that the vaccine is not likely to be as effective in this age group as in older children. These younger children may need a second dose of vaccine within 18 months following the initial dose to ensure protection. Additional data regarding the duration of the antibody response are needed to define the timing of a second dose more precisely.

   Children who attend day-care facilities are at particular risk of acquiring systemic Hib disease. Initial vaccination at 18 months of age for this high-risk group should be considered.

   Children with chronic conditions known to be associated with increased risk for Hib disease should receive the vaccine, although only limited data on immunogenicity and clinical efficacy in this group are available. These conditions include anatomic or functional asplenia, such as sickle cell disease or splenectomy (*14*), and malignancies associated with immunosuppression (*15*).
3. **Immunization of individuals over 24 months of age who have not yet received Hib vaccine should be based on risk of disease.** The risk of invasive Hib disease decreases with increasing age over the age of 2 years. Because the vaccine is safe and effective, however, physicians may wish to immunize previously unvaccinated healthy children between 2 years and 5 years of age to prevent the Hib disease that does occur in this age group. The potential benefit of this strategy in terms of cases prevented declines with increasing age of the child at the time of vaccination. Therefore, children 2-3 years of age who attend day-care facilities should be given a higher priority than day-care attendees who are 4-5 years old.
4. **Insufficient data are available on which to base a recommendation concerning use of the vaccine in older children and adults with the chronic conditions associated with an increased risk of Hib disease.**
5. **Vaccine is not recommended for children under 18 months of age.**
6. **Simultaneous administration of Hib and DTP vaccines at separate sites can be performed, because no impairment of the immune response to the individual antigens occurs under these circumstances.**

SIDE EFFECTS AND ADVERSE REACTIONS

Polysaccharide vaccines are among the safest of all vaccine products. To date, over 60,000 doses of the Hib polysaccharide vaccine have been administered to infants and children and several hundred doses have been given to adults (*9,16*). Only one serious systemic reaction has been reported thus far—a possible anaphylactic reaction that responded promptly to epinephrine. High fever (38.5 C [101.3 F] or higher) has been reported in fewer than 1% of Hib vaccine recipients. Mild local and febrile reactions were common, occurring in as many as half of vaccinated individuals in the Finnish trial. Such reactions appeared within 24 hours and rapidly subsided. Current preparations appear to result in fewer such local reactions. Simultaneous administration with DTP does not result in reaction rates above those expected with separate administration (*17*).

PRECAUTIONS AND CONTRAINDICATIONS

The Hib vaccine is unlikely to be of substantial benefit in preventing the occurrence of secondary cases, because children under 2 years old are at highest risk of secondary disease. Because the vaccine will not protect against nontypeable strains of *H. influenzae*, recurrent upper respiratory diseases, including otitis media and sinusitis, are not considered indications for vaccination.

NEW VACCINE DEVELOPMENT

New vaccines, such as the Hib polysaccharide-protein conjugate vaccines, are being developed and evaluated and may prove to be efficacious for children under 18 months of age.

[References available upon request]

Reference: Centers for Disease Control, Morbidity and Mortality Weekly Report, Vol. 34/No. 15, April 19, 1985.

Reinstatement of Regular Diphtheria-Tetanus-Pertussis Vaccine Schedule

The status of diphtheria-tetanus-pertussis (DTP) vaccine availability in the United States and interim recommendations of the U.S. Public Health Service Interagency Group to Monitor Vaccine Development, Production, and Usage were recently reported (*1*). This statement recommended postponement of administration of the DTP vaccine doses usually given at ages 18 months and 4-6 years (fourth and fifth doses) until greater supplies are available.

Since November 1984, Lederle Laboratories has been distributing its own DTP vaccine, as well as that manufactured by Wyeth Laboratories. By following the recommendation of the Interagency Group, the quantities distributed have been sufficient to reduce the threat of critical shortages. On April 25, Connaught Laboratories announced its resumption of full-scale distribution of DTP vaccine and the availability of 2.2 million doses for immediate shipment. Connaught Laboratories will continue to produce vaccine at a level that will help meet U.S. needs.

Projected production schedules for the manufacturers indicate that supplies of DTP vaccine should be adequate to provide the normally recommended fourth and fifth doses of DTP and to provide the needed catch-up doses for children who have had them deferred.

In view of these developments, after consultation with members of the Immunization Practices Advisory Committee and Committee on Infectious Diseases of the American Academy of Pediatrics, the Interagency Group now feels that the interim recommendations no longer apply. Immunization providers should resume administration of the complete DTP schedule and implement recall procedures for children under 7 years of age whose fourth (18 month) and fifth (4-6 years) doses were deferred. It is especially important to make every effort to provide DTP vaccine doses to such children scheduled to enter kindergarten or first grade in the fall.

[Reference available upon request]

Reference: Centers for Disease Control, Morbidity and Mortality Weekly Report, Vol. 34/No. 16, April 26, 1985.

April Health Department

Calendar Set

Apr 1985

APRIL 4 Immunization Clinic 10 to 1 - Blood Pressure Clinic 2 to 4
APRIL 5 Well Child Clinic (Appointment)
APRIL 9 WIC (Appointment)
APRIL 12 Well Child Clinic (Appointment)
APRIL 15 Board of Health Monthly Meeting 12:00 noon
APRIL 16 WIC (Appointment)
APRIL 17 Food Handlers Class 8:00 A.M.
APRIL 18 WIC (Appointment - Immunization Clinic 5 to 7 P.M.
APRIL 19 Well Child Clinic (Appointment)
APRIL 26 Well Child (Appointment) - Commodities Distribution for Low Income 10:00 A.M.

Wasatch City-County
Health Dept.
55 West Center
Heber City, Utah 84032
654-2700

April Health Department

Calendar Set

4 Apr 1985

APRIL 4 Immunization Clinic 10 to 1 - Blood Pressure Clinic 2 to 4
APRIL 5 Well Child Clinic (Appointment)
APRIL 9 WIC (Appointment)
APRIL 12 Well Child Clinic (Appointment)
APRIL 15 Board of Health Monthly Meeting 12:00 noon
APRIL 16 WIC (Appointment)
APRIL 17 Food Handlers Class 8:00 A.M.
APRIL 18 WIC (Appointment - Immunization Clinic 5 to 7 P.M.
APRIL 19 Well Child Clinic (Appointment)
APRIL 26 Well Child (Appointment) - Commodities Distribution for Low Income 10:00 A.M.

Wasatch City-County
Health Dept.
55 West Center
Heber City, Utah 84032
654-2700

Clinic Scheduled

4 Apr 1985

Beginning in April, the Wasatch City-County Health Department will hold immunization clinics twice a month. The clinics will be held on the:

FIRST THURSDAY of each month from 10:00 A.M. to 1:00 P.M.

THIRD THURSDAY of each month from 5:00 to 7:00 P.M.

Appointments are not necessary.

Immunizations may also be obtained from your family physician. We urge all parents to insure that their children are protected against preventable disease.

For further information, please call 654-2700.

Wasatch City-County
Health Dept.
55 West Center
Heber City, Utah 84032

Health Department

June Calendar Set

30 May 1985

June 3, Food Handler's Class 8:00 a.m.

June 4 WIC Appt. necessary

June 6 Immunization Clinic 10-1, Blood Pressure Clinic 2-4

June 7 Well Child Clinic appt. necessary

June 11 WIC Appt. necessary

June 13 WIC Appt. necessary

June 14 Well Child Clinic Appt. necessary

June 15 County Health Fair, 10-2 Senior Citizens Center, Everyone is welcome.

June 17, Board of Health Meeting, 12 noon.

June 18 WIC

June 19 Food Handlers Class 5 p.m. Early Pregnancy Class 7 p.m.

June 20 Well Child Clinic Appt. necessary

June 28, Well Child Clinic Appt. necessary.